Billing Code:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PUBLIC HEALTH SERVICE

INDIAN HEALTH SERVICE

INJURY PREVENTION PROGRAM FOR

AMERICAN INDIANS AND ALASKA NATIVES:

COOPERATIVE AGREEMENT APPLICATION ANNOUNCEMENT

AGENCY: Indian Health Service, HHS

ACTION: Notice of Competitive Cooperative Agreement Applications for an Injury Prevention Program for American Indians and Alaska Natives.

SUMMARY

The Indian Health Service (IHS) announces that competitive cooperative agreement applications are now being accepted for the Injury Prevention Program for American Indians and Alaska Natives. These cooperative agreements are established for demonstration projects under the authority of section 301(a), Public Health Service Act, as amended. There will be only one funding cycle during fiscal year (FY) 2004. This program is described at 93.284 in the Catalog of Federal Domestic Assistance. These cooperative agreements will be awarded and administered in accordance with (1) this announcement; (2) 45 CFR part 92, "HHS Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments," or 45 CFR part 74, "Administration of Grants to Non-profit Recipients"; (3) the Public Health Service (PHS) Grants Policy Statement; and (4) applicable Office of Management and Budget Circulars.

Executive Order 12372 requiring intergovernmental review is not applicable to this program.

Smoke Free Workplace:

The PHS strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of all tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Eligible Applicants

Any federally recognized Indian tribe or tribal organization is eligible to apply for these grants. A tribal organization can be consortiums, groups of tribes, or an organization whose mission is to serve American Indian/Alaska Native people. Urban Indian organizations including both Title V contractors and urban Indian organizations funded under the National Institute of Alcohol Abuse and Alcoholism (NIAAA) are also eligible to apply. Nonprofit organizations serving primarily AI/AN are eligible to apply. For Part I "Basic/Enhanced Injury Prevention Program" funding, tribes, tribal organizations, urban Indian organizations, and nonprofit organizations must have a minimum population size of 2,500 people, or serve 2,500 American Indian/Alaska Native people. There is no minimum population size for Part II applicants.

Availability of Funds

Approximately $295,000 is available in FY 2004 (awaiting year 2004 budget) to fund up to approximately 8 new awards. There are two separate types of grants covered under this announcement:

Part I: Funds are available to fund up to 5 new awards for Basic Core Capacity Injury Prevention

Program Development or Enhanced Injury Prevention Program Development. Individual awards can be up to $50,000.

Part II: Funds are available to fund up to 3 awards to implement proven or promising injury intervention projects that are based on addressing local injury problems. Individual awards can be up to $15,000.

Tribes, tribal organizations, urban organizations, and nonprofit organizations serving primarily AI/AN may apply for new funding under Parts I, or II, but only one award will be funded from each applicant. Tribes, tribal organizations, and urban organizations currently funded with a Part I cooperative agreements are not eligible. A separate application is required for each type of project as listed in Parts I, or II.

Projects are expected to begin on or about October 1, 2003, and will be made for a 12-month budget period within a project period of:

- 2 years for Core Capacity Building projects (Part I); and
- 2 years for Injury Intervention projects (Part II).

Continuation awards within the project period will be based upon satisfactory performance, availability of funding, and continuing needs of the IHS.

Applicants to this Injury Prevention Cooperative Agreement Announcement are not legislatively required to provide matching funds or cost sharing. Applicants may elect to include cost sharing in their proposal. Applicants may refer to the Frequently Asked Questions (FAQS) link at the website www.hhs.gov/grantsnet for references on cost sharing.

Application Submission and Deadline:

a. Application Receipt Date - An original and two copies of the completed grant application must be submitted with all required documentation to the Grants Management Branch, Division of Acquisition and Grants Management, 801 Thompson, Suite 120, Rockville, Maryland 20852, by close of business July 15, 2003. Applications shall be considered as meeting the deadline if they are either: (1) received on or before the deadline with hand-carried applications received by close of business 5 p.m. or (2) postmarked on or before the deadline. A legibly dated receipt from a commercial carrier or the U.S. Postal Service will be accepted in lieu of a postmark. Private metered postmarks will not be accepted as proof of timely mailing. Late applications not accepted for processing will be returned to the applicant and will not be considered for funding. Acknowledgement of Receipt: Acknowledgement of receipt of applications will be via the Application Receipt Card, IHS 815-1A (Rev, 4/97).

b. Additional Dates:

1. Applicants will be notified of results after October 1, 2003 (approved, recommended for approval but not funded, disapproved, or ineligible).
2. Anticipated Start Date: October 1, 2003.

CONTACTS FOR ASSISTANCE:

If you have questions after reviewing the contents of all the documents, you may contact Ms. Patricia Spotted Horse, Grants Management Specialist, Grants Management Branch, Indian Health Service, 801 Thompson, Suite 120, Rockville, Maryland 20852, telephone (301) 443-5204, regarding business management technical questions. To obtain additional application kits, contact telephone (301) 443-5204. Programmatic technical assistance regarding the Injury Prevention Grant Program for American Indians and Alaska Natives may be obtained from Mr. Alan Dellapenna, MPH, internet address: adellape@hqe.ihs.gov telephone (301) 443-0097.

PROGRAM INFORMATION:

This announcement provides information on the general program purpose, eligibility and documentation, project types, funds available, limitations, period of support, and application procedures for FY 2003.

A. BACKGROUND

Traumatic injuries are a serious public health problem among American Indians and Alaska Natives, and thus injury prevention is a top priority for the Indian Health Service (IHS). Injuries are the leading cause of death among American Indians and Alaska Natives between the ages of 1 and 44 years, and the third leading cause of death overall (National Center for Injury Prevention and Control, Centers for Disease Control, [CDC] http://www.cdc.gov/ncipc/wisqars/). The age adjusted injury death rates for Native Americans are approximately two to three times that of all other Americans (Indian Health Service, *Trends in Indian Health, 1997*). Some of the leading causes of injury death for Indian people are car/pedestrian crashes, suicides, homicides, poisoning, drowning, and residential fires (National Center for Injury Prevention and Control, CDC, Appendix). Other important injury causes include domestic violence and youth violence.

The Public Health Model

These types of injuries are not accidental–they do not happen by chance. The problem of injury can be approached through the same methods that have led to success in preventing infectious disease. The IHS and the National Center for Injury Prevention and Control, CDC, both use the public health model to address injuries, and this model is the foundation for the Injury Prevention Program. The public health approach has been proven to be effective and has four components:

1) Defining the nature and extent of the injury problem by collecting local injury data, such as from police, hospitals, EMS, and fatality reports.

2) Identifying risk factors and causes for injury, such as what age groups are most at risk, alcohol involvement, etc.
3) Choosing an appropriate proven or promising intervention to prevent the injury; and
4) Implementing an effective intervention strategy in a manner culturally appropriate for the target community and evaluate from the early stages if the program is having an effect.

The IHS Injury Prevention Program

The IHS, at the national and Area level, has traditionally taken a prominent role in the development and implementation of American Indian and Alaska Native injury prevention programs. This leadership role was needed in order to develop, implement, and evaluate injury prevention programs that would be successful in reducing American Indian and Alaskan Native morbidity and mortality related to injuries. While this approach has been successful, the funds in this announcement will significantly increase the capacity of tribes and tribal/urban/nonprofit Indian organizations to build and sustain their own community-based injury prevention programs.

B. GENERAL PROGRAM PURPOSE

The purposes of the Injury Prevention Program are to:

1) Provide “seed” funding for tribes and tribal/urban/nonprofit Indian organizations to establish basic programmatic core capacity to conduct effective community-based injury prevention programs. For these programs to be successful, those awarded must use this funding as a stable base to then seek other internal and external partners interested in reducing injuries. One of the goals of the program is that after the grant period is completed, the tribal injury prevention program would continue as a valuable tribal or urban Indian public health program.

2) Provide Federal funding to assist tribes and tribal/urban/nonprofit Indian organizations in implementing intervention programs based upon sound epidemiological data and proven interventions.

C. (TRIBAL, URBAN, NONPROFIT) SUPPORT AND DOCUMENTATION

Some documentation of tribal support is required, and those items are noted. Applications will be stronger if support is documented from others as listed below.

1) Evidence of (Urban) Support: A signed and dated resolution from the governing Board of Directors for the Injury Prevention program as well as a letter from the Chairman of the Board **(Required).**

(a) A letter of commitment showing in-kind (dollar) participation, if applicable.

(b) Letters of support from within the community served.

2) Evidence of (Tribal) Support: Examples of tribal support include but are not limited to:

a) Resolutions;

(1) Signed and dated resolution(s) for the Tribal Injury Prevention Program from the Indian tribe or tribes served by the project **(Required)**. Those tribes that cannot get a resolution signed in time to meet the deadline should submit a draft of the resolution in the appendix. A signed resolution from the tribe will be required prior to award if the tribe is selected for a cooperative agreement. For the Navajo Nation, where getting a tribal resolution signed is often difficult, signed resolutions from a local governing body, such as a Chapter House, will be acceptable for the intent to participate. A signed resolution from the Navajo Nation will be required prior to award if a Chapter House is selected for a Cooperative Agreement.

(2) Applications that propose projects affecting more than one Indian tribe must include resolutions from all affected tribes to be served.

(3) Applications by tribal organizations will not require a specific tribal resolution(s) if the current tribal resolution(s) under which they operate would encompass the proposed grant activities. A statement of proof or a copy of the current operational resolution must accompany the application. If a resolution or a statement is not submitted, the application will be considered incomplete and will be returned without consideration.

b) A description of any current tribal financial support for injury prevention (for example, the tribe operates a child safety seat program or funds other injury prevention programs);

c) Letters of support from the tribal chairperson, the tribal council, or the tribal health director in support of the application (**required**);

d) A description of tribal in-kind contributions for the injury prevention program. (What support, if any, is the tribe providing to this application, such as office space, administrative support, telephone service, employee fringe benefits, etc., or any other contribution to the proposed program);

e) Letters of support from IHS Area or District injury prevention specialists. For over a decade, the IHS has had full-time injury prevention specialists working to prevent injuries at the Area level, and in some cases, the District office level as well. These injury prevention specialists are knowledgeable of effective intervention strategies and experienced in the technical aspects of an injury program. One of the goals of the Injury Prevention Grant Program is that the District and/or Area IHS injury prevention specialists will be engaged as partners with the tribes and tribal/urban Indian organizations;

f) Letters of Support/Collaboration from potential project collaborators or partners. Support from potential partners such as the police department, tribal health department, tribal council, local schools, community groups, the Indian Health Service, State agencies, and others are important for a program to be successful.

3) Evidence of (Nonprofit) Support: Nonprofit organizations must submit

a) Copies of their 501 (C) (3) Certificate (**required**).

b) A signed and dated resolution from the governing Board of Directors of the nonprofit organization (**required**).

c) Letters of support from the AI/AN community served (**required**).

d) Letter of support from IHS Area and/or District Injury Prevention Specialist (**required**).

e) Letters of support/cooperation/collaboration/assistance from partner organizations. Letters should be specific to this program.

All letters of support and commitment to this project should be detailed, specific, and included in the Appendix.

D. PROJECT TYPES

The IHS Injury Prevention Program funds two different types of projects, including projects that seek to accomplish the following objectives:

1) Build or enhance local injury prevention capacity (Part I); or

2) Implement a proven or promising injury prevention intervention (Part II).

A tribe, tribal organization, urban Indian, or nonprofit organization is eligible to apply for one or both of these types of projects, **but only one grant will be funded from each applicant. Tribes, tribal organizations, or urban Indian organizations currently funded with Part I projects are not eligible.** This provision allows the greatest number of applicants the maximum opportunity to participate in the program. If an applicant chooses to submit dual proposals, the cover letter should rank the proposals in the order that the applicant would like them to be funded. For example, if both a Part I and Part II application were submitted (and both scored well during the review process), then IHS would need to know which application to fund.

A separate application must be submitted for each Part (type of project) for which funding is requested.

Project Type Descriptions:

Part I: Building or Enhancing Local Injury Prevention Capacity

This program is designed to allow tribes and tribal/urban/nonprofit Indian organizations (**serving a minimum population size of 2500 people or more**) to develop or strengthen their organizational focus in prevention and control of injuries. Some may have already established basic injury prevention programs within their health departments or emergency medical services systems. **Applicants wishing to enhance those programs should identify how grant funds awarded through this program will allow them to increase their current injury prevention program capacity.** Examples would include: (1) enhanced linkages or partnerships with others; or (2) evaluations of the impact of their program; or (3) initiation of a new program focus, such as intentional injuries or a comprehensive fire/burn prevention program.

A comprehensive Injury Prevention Program would entail all or some of these types of activities:

- Conducts data collection, analysis, and reporting of local injury problems.
- Involves the community in planning, implementation, and evaluation of injury programs.
- Promotes collaboration and partnerships at local, State, and national levels.
- Recruits an advisory panel of experts such as the IHS, police, concerned citizens, hospital staff, and other individuals with interest or expertise in injury prevention and control to assess the injury prevention needs of the community, and begin planning a tribal or urban injury prevention program.

- Conducts community-based interventions to reduce injuries based on effective strategies and local data.
- Obtains both tribal and external funding or obtains both urban and external funding.
- Develops an injury prevention strategic plan for the tribe or tribal/urban/nonprofit Indian organization.
- Advocates for injury prevention at all levels of tribal or urban decision-making.
- Provides consultation and technical assistance to other agencies and programs.
- Evaluates its own program effectiveness and costs.
- Conducts studies of specific local injury problems.
- Develops recommendations for policies, regulations, and laws to prevent injuries.
- Provides training opportunities for staff.

Part I - Cooperative Activities

In conducting activities to achieve the purpose of this program under Part I, the grant recipient (tribe or tribal/urban/nonprofit Indian organization) will be responsible for the activities listed under a, and IHS will be responsible for activities listed under b.

a. Part I – Project Recipient Activities:

- Where possible, locate the Injury Prevention Program in the recipient's urban organization or in their tribal health department to enhance opportunities for the injury prevention program to collaborate with other tribal public health programs.
- Provide a full-time coordinator who has the authority, responsibility, and expertise to conduct and manage the tribal-level, multi-tribal, urban, or nonprofit injury prevention program.
- Establish an advisory group to address issues relevant to injury prevention and control for the

recipient. This group may consist of public and private individuals, organizations, agencies, and groups such as IHS injury specialists, police, violence prevention programs, hospital staff, EMS staff, injury experts, and others.

- Analyze existing data to define the magnitude of the injury problem within the target American Indian/Alaska Native population, including those at greatest risk and the specific causes of injury. Potential data sources include hospital clinic discharge data (IHS, tribal, urban, or contract health service hospitals), clinic and emergency department data (IHS, tribal, urban referral center, and others), fire incident reports, police reports, State Department of Transportation reports, fatality statistics, child death reviews, and EMS run sheets.
- Develop an action plan based on data and prioritized for the prevention and control of injuries. This would include specific process and impact objectives and action steps to accomplish each.
- Implement community-based programs to reduce injuries and gain visibility and acceptance in the communities for the injury control program.
- Evaluate the effect of these programs.
- The project coordinator or director will budget for and attend a start-up orientation meeting with other new project coordinators, IHS Injury Prevention Program staff, and IHS consultants. An annual regional tribal project coordinator/IHS project officer meeting will be held for each subsequent year of the project cycle, and should be budgeted.
- The tribal injury program coordinator director will collaborate with the IHS injury prevention Area and/or District specialists and an IHS contractor who may provide technical assistance oversight, conference calls, a newsletter, and annual site visits.

b. Part I - IHS Activities:

- An identified IHS Injury Specialists (Area or District) will serve as project officer for the injury prevention project and will be responsible to provide technical assistance and consultation to the recipient on program planning, data collection and analysis, program implementation, evaluation, and dissemination of results.
- An IHS contractor will provide technical assistance oversight, regular conference calls, a newsletter, and annual site visits.
- IHS and the Contractor will coordinate an annual training workshop for injury prevention project coordinators and their IHS project officers to share lessons learned, successes, and strategies to reducing injuries in Indian communities.

Part II: Implement Proven or Promising Injury Prevention Interventions

Part II funds are to be used to develop, implement, and evaluate proven or promising injury prevention intervention programs. These types of interventions are those that have been tested and accepted widely to prevent injury morbidity and mortality. An application for this type of project would first involve the collection of baseline data that shows a particular injury problem exists in a tribe or community. Based on this data, the project would address the problem with an intervention and then evaluate the program's success. Projects include, but are not limited to, working with police to conduct sobriety checkpoints to reduce drinking and driving, seat belt wearing campaigns combined with police enforcement, smoke alarm distribution programs, pedestrian safety, domestic violence programs, suicide prevention, youth violence prevention, drowning prevention, programs designed to reduce alcohol-related injuries, and child safety seat distribution and enforcement campaigns.

Part II - Cooperative Activities

In conducting activities to achieve the purpose of this program under Part II, the recipient will be responsible for the activities listed under a, and the IHS will be responsible for activities listed under b.

a. Part II - Recipient Activities:

- Provide a coordinator who has the authority, responsibility, and expertise to conduct and manage the injury intervention program.
- The Injury Intervention Coordinator will collaborate with the IHS Area and/or District Injury Prevention Specialists in planning and designing the intervention program.
- Develop an intervention plan which is based on local data, and which utilizes proven or promising intervention strategies to reduce injuries.
- Implement the injury intervention program and promote visibility and acceptance in the community for the program.
- Evaluate the effects of the program.

b. Part II - IHS Activities:

IHS Area or District Injury Prevention Specialist will provide technical assistance and consultation to the recipient on program planning, data collection and analysis, program implementation, evaluation, and dissemination of results.

E. LIMITATIONS OF SUPPORT

Limitations – Delinquent Federal Debts – No award shall be made to an applicant who has an outstanding debt until either:

- The delinquent account is paid in full,

- A negotiated repayment schedule is established and at least one payment is received, or
- Other arrangements satisfactory to IHS are made.

F. THE TRIBAL INJURY PREVENTION APPLICATION KIT

An application kit may be obtained by contacting Mr. Pallop Chareonvootitam, Grants Clerk, Grants Management Branch, Division of Acquisition and Grants Management, IHS, 801Thompson, Suite 120, Rockville, Maryland 20852, telephone (301) 443-5204.

G. GRANT APPLICATION REQUIREMENTS

NOTE: The IHS is accepting only paper applications at this time.

A separate application must be submitted for each Part (I and II) for which funding is requested. **All applications must be double-spaced**, typewritten, and consecutively numbered pages using black type not smaller than 12 characters per one inch, with conventional one-inch border margins, on only one side of standard size 8-1 /2 X 11 paper that can be photocopied. The application narrative (not including the Appendix and supporting documents) must not exceed 20 typed pages for Part I applications, and 15 pages for Part II applications.

The applicant should provide a detailed description of first-year activities and briefly describe second year objectives and activities on a separate page. Descriptions of the second year activities should be placed in the appendix.

All applications must include the following in the order presented:

Supporting Documents:

- Evidence of project support.
- Standard Form 424, Application for Federal Assistance signed by the authorized official.
- Standard Form 424A, Budget Information - Non-Construction Programs and instructions (pages 1 - 2).
- SF 424B - Assurances - Non-Construction Programs (front and back).
- Certifications (PHS-5161-1 - pages 17, 18, and 19).
- PHS-5161-1 Checklist – pages 25 and 26
- NOTE: (The PHS-5161-1 application forms are available at the following website: http://www.hhs.gov/grantsnet under the Electronic Roadmap to Grants link and the Standard Forms link)

Project Narrative

Budget

Appendix (list contents)

H. APPLICATION NARRATIVE INSTRUCTIONS, AND APPLICATION STANDARDS (EVALUATION CRITERIA) AND WEIGHTS

The instructions for preparing the application narratives and evaluation criteria for Parts I, and II are each listed separately in the Narrative sections below. Weights that will be assigned to each section are noted in parentheses.

For **Part I applicants,** additional weights will also be considered. Applications demonstrating that project staff who will be responsible for coordinating injury prevention program activities and interventions have received previous training in injury prevention will receive additional points as listed below. Course completion certificates and a verification letter from the IHS Area Injury

Prevention Specialist must be provided for points to be awarded.

- Graduates of the United Tribes Technical College Injury Prevention Associate Degree Program or the IHS Injury Prevention Fellowship Program: 15 points.
- Completion of all three IHS Injury Prevention training courses (Introduction to Injury Prevention – level I, Intermediate Injury Prevention – Level II, and Advanced Injury Prevention – Level III): 10 points
- Completion of one or two of the IHS Injury Prevention training courses listed above: 5 points.

NARRATIVE:

I. For Basic or Enhanced Injury Prevention Programs (Part I), the application must include:

A. Abstract:

Provide a one-page summary of the proposed program. State whether applying for a Basic or Core Capacity Injury Prevention Development Enhanced Injury Prevention Program.

B. Background, Need for Assistance, and Capacity:

Provide a description of the injury problems among Indian people served by the proposed project.

- How serious is the injury problem in the community?
- Describe any current and past injury control activities that may have occurred in the community or project area.
- Justify the need to develop a basic or enhanced injury prevention and control program.

- Describe the benefit of creating or enhancing an injury prevention and control program for the community or target population.
- Demonstrate the capacity to conduct the program.
- Provide documentation that the target population size is at least 2,500 people.
- Describe the extent of support for this program, such as through passage of any tribal resolutions or any supporting documentation from urban Board for injury prevention (in general or for this project).
- Describe any financial support or in-kind contributions for injury prevention or this project.
- Include a letter of support from the Administration that will ensure grant funds are used specifically for the injury prevention activities proposed.

C. Goals and Objectives:

Provide specific goals that indicate what the applicant anticipates its **Basic Core Capacity or Enhanced Injury Prevention Program** will have accomplished at the end of the project period. Include specific time-framed, measurable, and achievable objectives that can be accomplished during the first year budget period, and a general plan of activities for year 2.

Objectives should relate directly to the project goals. Include objectives that address all activities necessary to accomplish the purpose of the proposal. Specifically, they should include, but not be limited to:

- Creation of an advisory committee,
- Collecting local injury or risk factor data,
- Producing a profile of injuries in the target population, and

- Developing a plan to prevent injuries at the community level.

Include a work plan for each objective that indicates (1) when the objectives and major activities will be accomplished, (2) lead responsibilities, and (3) a time line to monitor progress. Any proposed injury intervention strategies should be proven or promising, and based on a documented injury problem.

D. Methods and Staffing:

Describe how the program will be implemented. Provide:

1. A detailed description of proposed activities designed to achieve each objective and overall program goals that includes designation of responsibility for each activity undertaken;
2. A complete time frame indicating when each activity will occur; and
3. A description of the roles of each unit, organization, or agency and the coordination, supervision, and degree of commitment (e.g., time, in-kind, financial) of staff, organizations, and agencies involved in activities.

Also:

- Show allocation of staff to the activities.
- Describe the roles and responsibilities of the project director/coordinator and any staff member. Descriptions should include the position titles, education and experience required, and the percentage of time each will devote to the program.
- If staff will be hired, include a resume or position description that clearly describes the position and its duties, indicating desired qualifications and experience requirements related to the project.

- If personnel are already identified for specific positions, their resumes should be included in the Appendix and indicate that the proposed staff is qualified to carry out project activities.

E. Evaluation:

Describe how the success of the program will be evaluated. Describe how it will be determined if the proposed project's objectives were achieved and how proposed evaluation measures will measure success in developing basic or enhanced injury prevention programs. Document staff availability, expertise, experience, and capacity to perform the evaluation. Include a plan for reporting evaluation results and using evaluation information for programmatic decisions.

F. Coordination and Collaboration:

Provide a description of the relationship between the program and other organizations, agencies, and groups that will form the core advisory group for the program. Composition and roles for the advisory structure and other partners should be included; specific letters of support should be provided in the Appendix.

G. Budget and Accompanying Justification:

Provide a detailed budget with accompanying narrative justifying all individual budget items that make up the total amount of funds requested.

1) The budget should be consistent with stated objectives and planned activities of the project.
2) Include a current indirect cost rate agreement.
3) The year 1 budget should include travel and per diem expenses for the Injury Prevention Project Coordinator to participation in an orientation meeting in Washington DC. Within 3 months of project award date, Part I projects sites are required to send at least one

representative to a project orientation meeting. This meeting will be designed to inform Part I injury prevention projects about the IHS Injury Prevention Program, the rules and regulations of the Injury Prevention Cooperative Agreement Program, and project monitoring procedures for the project sites. The meeting also serves as an opportunity for networking, collaboration, and the identification of technical assistance needs.

4) Both years budget should include travel and per diem expenses to Washington DC for the Injury Prevention Project Coordinator to participate in the annual Project Coordinator's Meeting. Part I project sites will be required to send at least one representative to a nationally held training workshop. Newly funded project sites will join the 24 currently funded project coordinators at the workshop. The workshops will be an opportunity for project coordinators to share challenges, lessons learned, and success stories. The training workshop topics and activities will be tailored to the needs of attendees and will also serve as an opportunity for networking, collaboration, and the provision of technical assistance.

PART I EVALUATION CRITERIA

Part I applications will be reviewed and evaluated according to the following criteria:

A. Background, Need, and Capacity (30 points):

The application will be evaluated on

1. The extent to which the applicant presents information documenting the extent of the injury problem in the community or target area;
2. The extent to which the applicant has shown the capacity to accomplish the program, including the description of positive progress in any related past or current injury prevention activities or programs; and
3. The extent to which the applicant has shown tribal or organizational support for the proposed program or injury prevention in general.

B. Goals and Objectives (10 points):

The application will be evaluated on the extent to which the applicant includes

- Goals that are relevant to the purpose of the proposal,
- Feasible to accomplish during the project period, and
- Are specific and measurable.

The application will also be evaluated on the extent to which the applicant has included objectives that are:

- Feasible to accomplish during the budget period;
- Address all activities necessary to accomplish the purpose of the proposal; and
- Are specific, time-framed, measurable, and realistic.

C. Methods and Staffing (30 points):

The application will be evaluated on the extent to which the applicant provides:

1. A detailed description of proposed activities that are likely to achieve each objective and overall program goals, and which includes designation of responsibility for each action undertaken;
2. A reasonable and complete schedule for implementing all activities; and
3. A description of the roles of each unit, organization, or agency and evidence of coordination, supervision, and degree of commitment (e.g., time, in-kind, financial) of staff, organizations, and agencies involved in activities. The application will also be evaluated on
    a) The extent to which proposed interventions are either proven or promising to be effective and based on a documented need in the target communities, and

b) The extent to which resumes are included for existing staff, and detailed position descriptions and duties are included for projected staff.

Extra points for hiring staff trained in injury prevention will also be awarded (see Section H, Application Narrative Instructions) based on the following:

- Graduates of the United Tribes Technical College Injury Prevention Associate Degree Program or the IHS Injury Prevention Fellowship Program: 15 points.
- Completion of all three IHS Injury Prevention training courses: 10 points.
- Completion of one or two of the IHS Injury Prevention training courses: 5 points.

For consideration of extra points, applicants must submit proof of the training, such as the name of the person, date of training, location, and copy of course completion certificate.

D. Evaluation (10 points):

The application will be evaluated on the extent to which the proposed evaluation system is:

- Detailed;
- Addresses goals and objectives of the program; and
- Will document program process, effectiveness, and impact.

The applications will also be evaluated on the extent the applicant demonstrates:

- Potential data sources for evaluation purposes and methods to evaluate the data sources;
- Documents staff availability, expertise, experience, and capacity to perform the evaluation; and
- Includes a feasible plan for reporting evaluation results and using evaluation

information for programmatic decisions.

E. Collaboration (10 points):

The application will be evaluated on (1) the extent to which relationships between the program, the tribe or urban community, the Indian Health Service and other organizations that will relate to the program or conduct related activities are clear and complete; and (2) the extent to which the advisory committee or partners' roles are clear and appropriate.

F. Budget and Justification (10 points):

The application will be evaluated on the extent to which the applicant provides a detailed budget and narrative justification consistent with stated objectives and planned program activities.

II. For Implementing Proven or Promising Injury Intervention Projects (Part II), the application must include:

A. Abstract:

Provide a one-page summary of the proposed intervention program.

B. Background, Need for Assistance, and Capacity:

Provide a description of the injury problems among Indian people served by the proposed project. How serious is the injury problem in the community? Describe any current and past injury control activities that may have occurred in the community or project area. Justify the need to implement an injury prevention and control intervention program. Demonstrate the capacity to conduct the program. Describe the extent of tribal or urban support for this program, such as support of for injury prevention activities in general or for this specific project. Describe any financial support or in-kind contributions for injury prevention or this project. Include a letter of support from the Administration that will

ensure IHS funds are used specifically for the injury prevention activities proposed.

C. Goals and Objectives:

(Note: See Addenda Section for an "Outline for an Injury Intervention Program" which may be helpful).

Refer to Page 4 for application requirements for Part I and Part II.

Provide specific goals that indicate what the applicant anticipates its **Proven or Promising Injury Intervention Program** will have accomplished at the end of the project period. Include:

- Specific time-framed, measurable, and achievable objectives that can be accomplished during the first year budget period, and
- A general plan of action for year 2.

Objectives should relate directly to the project goals. Include objectives that address all activities necessary to accomplish the purpose of the proposal. Specifically, they should include, but not be limited to, analyzing local injury or risk factor data and developing an implementation plan for the proposed intervention to prevent injuries at the community level. Include a work plan for each objective that indicates when the objectives and major activities will be accomplished, lead responsibilities, and a time line to monitor progress. Any proposed injury intervention strategies should be proven or promising and based on a documented injury problem.

D. Methods and Staffing:

Describe how the program will be implemented. Provide:

1) A detailed description of proposed activities designed to achieve each objective and overall program goals that includes designation of responsibility for each activity undertaken;

2) A complete time frame indicating when each activity will occur; and

3) A description of the roles of each unit, organization, or agency and coordination, supervision, and degree of commitment (e.g., time, in-kind, financial) of staff, organizations, and agencies involved in activities.

Show allocation of staff to the activities. Describe the roles and responsibilities of the project director/coordinator and any staff member. Descriptions should include the position titles, education and experience required, and the percentage of time each will devote to the program. If staff will be hired, include a resume or position description that clearly describes each position and its duties, indicating desired qualifications and experience requirements related to the project. Resumes should be included and should indicate that the proposed staff is qualified to carry out project activities.

E. Evaluation:

Describe how the success of the intervention program will be evaluated. Describe how it will be determined whether the proposed project's objectives were achieved and how the proposed evaluation measures will measure the intervention programs success in reducing injury hazards, changing local regulations, changing behaviors, and/or reducing injuries. Document staff or program partner availability, expertise, experience, and capacity to perform the evaluation. Include a plan for reporting evaluation results and using evaluation information for programmatic decisions.

F. Coordination and Collaboration:

Provide a description of the relationship between this program and other organizations, agencies, and groups that may be partners or collaborators in implementing the intervention program. Composition and roles for any partners should be included; specific letters of support should be provided in the Appendix.

G. Budget and Accompanying Justification:

Provide a detailed budget with accompanying narrative justifying all individual budget items that make up the total amount of funds requested. Include the current Indirect Cost agreement. The budget should be consistent with stated objectives and planned activities.

PART II – EVALUATION CRITERIA

Part II applications will be reviewed and evaluated according to the following criteria:

A. Background, Need, **and** Capacity (30 points):

The application will be evaluated on

1) The extent to which the applicant presents data and information documenting the extent of the injury problem in the community or target area;
2) The extent to which the applicant has shown the capacity to accomplish the program, including a description of positive progress in any related past or current injury prevention activities or programs; and
3) The extent to which the applicant has shown tribal or organizational support for the proposed program or injury prevention in general.

B. Goals and Objectives (10 points):

The application will be evaluated on the extent to which the applicant includes goals that are relevant to the purpose of the proposal, feasible to accomplish during the project period, and are specific and measurable. The application will also be evaluated on the extent to which the applicant has included objectives that are feasible to accomplish during the budget period, that address all activities necessary to accomplish the purpose of the proposal, and that are specific, time-framed, measurable, and realistic.

C. Methods and Staffing (30 points):

The application will be evaluated on the extent to which the applicant provides:

1) A detailed description of proposed activities which are likely to achieve each objective and overall program goals, and which includes designation of responsibility for each action undertaken;
2) A reasonable and complete schedule for implementing all activities; and
3) A description of the roles of each unit, organization, or agency, and evidence of coordination, supervision, and degree of commitment (e.g., time, in-kind, financial) of staff, organizations, and agencies involved in activities.

The application will also be evaluated on:

1) The extent to which proposed interventions are either proven or promising to be effective, and based on a documented need in the target communities, and
2) The extent to which resumes are included for existing staff, and detailed position descriptions and duties are included for projected staff.

D. Evaluation (10 points):

The application will be evaluated on the extent to which the proposed evaluation system is detailed, addresses goals and objectives of the program, and will document program process, effectiveness, and impact. The application will also be evaluated on the extent to which the applicant demonstrates potential data sources for evaluation purposes and methods to evaluate the data sources; documents staff availability, expertise, experience, and capacity to perform the evaluation; and includes a feasible plan for reporting evaluation results and using evaluation information for programmatic decisions.

E. Collaboration (10 points):

The application will be evaluated on the extent to which relationships between the program, the

tribe or urban community, the Indian Health Service, and other organizations that will relate to the program or conduct related activities are clear and complete, and the extent to which advisory committee or partners' roles are clear and appropriate.

F. Budget and Justification (10 points):

The application will be evaluated on the extent to which the applicant provides a detailed budget and narrative justification consistent with stated objectives and planned program activities.

Appendices for Parts I and II Applicants to include:

- ❖ Resumes and position descriptions for key staff.
- ❖ Chart or description of where the program staff will be located in the tribe or organization.
- ❖ Documentation of collaborative partnerships/letters of support.
- ❖ Timeline/Workplan.
- ❖ Second year objectives and activities past year 1 for Part I and II applicants.
- ❖ Documentation specifically related to injury prevention.
- ❖ Tribal/chapter resolutions, resolutions from urban boards.
- ❖ Copy of current negotiated indirect cost rate agreement.
- ❖ Application Receipt Card, IHS 815-1A (Rev. 4/97).

H. ASSURANCES

Refer to PHS-5161-1 Checklist

H. REPORTING REQUIREMENTS

1. Progress and Final Annual Reports – Three progress reports are due 15 days after the end

of each 4-month period of the project year. The progress reports will be in the format provided by the IHS project-monitoring contractor and will describe progress made towards the goals and objectives identified for the project. The third and final report for the year will include a brief description of program accomplishments, internal and external collaboration, new resources secured, intervention successes, and barriers identified.

2. Final Report – At the end of the 2-year funding cycle, a final report will be submitted
3. Financial Status Report - A final financial status report is due 90 days after expiration of the budget period. Standard Form 269 (long form) will be used for financial reporting.

J. Project ADMINISTRATION REQUIREMENTS

Projects are administered in accordance with the following documents:

1. 45 CFR part 92, HHS, "Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments," or 45 CFR part 74, "Administration of Grants to Non-Profit Recipients."
2. PHS Grants Policy Statement.
3. Appropriate Cost Principles: OMB Circular A-87, "State and Local Governments," or OMB Circular A-122, "Non-profit Organizations."
4. OMB Circular A-133, - Revised June 24, 1997, "Audits of States, Local Governments, and Non-Profit Organizations."

K. APPLICATION CONSIDERATION

1. Application Review: Applications submitted by the closing date and verified by the postmark under this program announcement will undergo an objective review to determine that the applicant is eligible in accordance with this announcement; that the application narrative, forms, and materials submitted are adequate to allow the reviewers to undertake an indepth

evaluation; and that the application complies with this announcement. Otherwise, the application will be returned without consideration.

2. Competitive Review of Accepted Applications: Applications meeting eligibility requirements that are complete, responsive, and conform to this program announcement will be reviewed for merit by reviewers appointed by the IHS. The review will be conducted in accordance with PHS review procedures. Part I applicants will undergo an objective review panel process. Field readers will review applicants submitting for Parts II funding. The review process ensures selection of quality projects in a national competition for limited funding. Applications will be evaluated and rated on the basis of the evaluation criteria listed above. These criteria are used to evaluate the quality of a proposed project, to assign a numerical score to each application, and to determine the likelihood of its success.
3. Results of the Review: The results of the review are forwarded to the Director, Office of Environmental Health and Engineering, for final review and approval. The Director will also consider the recommendations from the Manager, Injury Prevention Program, and the Grants Management Branch. After the decisions have been made on all applications, applicants are notified after October 1, 2003. Unsuccessful applicants will be notified in writing. Successful applicants are notified through an official Notice of Grant Award (NGA) document. The NGA will state the amount of Federal funds awarded the purpose of the grant, the terms and conditions of the grant award, the effective date of the award, the project period, and the budget period.

DATE _____

_____

Charles W. Grim, D.D.S., M.H.S.A.
Assistant Surgeon General
Interim Director

Date _____

_____
Michel E. Lincoln
Deputy Director

ADDENDA

The complete application kit includes a copy of the following listed addenda to provide the applicants with additional program guidance.

- **Budget Worksheets for assistance in completing the Budget section of application.**
- **Model Injury Programs in Indian Country, Effective Strategies, Sources of Injury Data.**
- **Injury Prevention Resources: books, websites, IHS training.**
- **Outline for an Injury Intervention Project.**
- **Leading Causes of Injury Death for American Indians and Alaska Natives.**
- **IHS Principal Injury Prevention Personnel.**

From: Indian Health Service
Handbook of Environmental Health (in press)
Model Injury Prevention Programs in Indian Country

One useful framework for conceptualizing the many approaches to injury prevention is termed the "4 E's". The four E's include education, environmental modification, engineering and enforcement. ***Education*** includes those efforts that use educational messages to persuade persons at risk of injury to change their behavior, such as installing smoke detectors. ***Environmental modification*** includes those efforts designed to reduce injury through the modification of environmental conditions that have been demonstrated to cause injury, such as roadway lighting. ***Engineering*** advances, such as seat belts and child safety seats have been highly successful in reducing injuries. Depending upon the nature of an injury, engineers are often able to design effective countermeasures to reducing that injury. ***Enforcement*** refers to the legislative regulations and the enforcement of those laws. Education and enforcement are active interventions while environmental modification and engineering for the most part are passive interventions. An injury prevention strategy that is able to utilize more than one method in a complementary way will likely be the most effective in reducing injuries among its target population.

Case Study: Motor Vehicle Safety on the Navajo Reservation

It has been well documented that motor vehicle-related death rates are extraordinarily high on many Indian reservations (IHS, Trends in Indian Health, 1997). In 1988 the motor vehicle death rate was five times greater on the Navajo Nation than in the rest of the country (CDC, Safety-Belt Use and Motor-Vehicle-Related Injuries-Navajo Nation. MMWR, 1992). Surveys conducted in the same year revealed that 14 percent of Navajo adults were wearing seat belts and seven percent of children were restrained in child safety seats. In response to these troubling statistics, the Navajo Area Indian Health Service, Navajo Department of Highway Safety, the Navajo Nation Tribal Council and others decided to collaborate on a joint initiative to pass a mandatory safety-belt law for the Navajo Nation to increase seat belt and child restraint usage by Navajo residents. The law was successfully passed in July of 1988.

In addition to passing a safety-belt law and enforcing that law, the intervention also included a comprehensive public awareness and education campaign. The pubic awareness and education component was initiated before the law was passed and continued well after enforcement began in 1989. The purpose of the campaign was to raise awareness of the problem of motor vehicle injuries among Navajo residents, provide information on the benefits of safety-belt use, and inform residents about the new law. After a grace period of approximately one year where police gave only warnings for non-compliance of the law, full enforcement was initiated and was wide spread by 1990. This was probably the most important phase of the intervention, as seat belt use went from 24% to 60% after enforcement was Navajo Nation wide.

The use of more than one intervention technique (in this case, education and enforcement) combined with a comprehensive campaign and the support of a broad based coalition ensured the success of this intervention. As a result, seat belt use has increased to about 70%, and injury hospitalization rates for motor vehicle occupants have decreased 45% among Navajo Nation residents since the law was passed.

Case Study #2: The Alaska Floatcoat Program

Drowning is the leading cause of injury death among Alaska Natives (firearms are the leading mechanism of injury death), with the majority of these deaths related to water craft. Because of the impact of injuries among Alaska Natives, the Yukon Kuskokwim Health Corporation (YKHC) collected local injury data to determine the causes and circumstances of injuries among the local Alaska Native residents. These data came from death certificates, coroner reports and trooper (police) reports. The data indicated that drowning was the leading cause of injury death, and that 75% of these drownings occurred in rivers while boating. To address this problem, the YKHC Corporation initiated the Alaska Floatcoat Program, an intervention that provides flotation coats (personal floatation devices, PFD) to Alaska Natives at wholesale cost.

The intervention began in 1990 with a public awareness campaign that presented the problem of drownings in the community and the use of float coats to prevent these drownings. The float coats were advertised in the newspaper, local radio, and in villages. The sale of floatcoats took place at the boat harbor, villages and at the local mini-mall. Floatcoat sales have increased each year since the programs inception, and mortality statistics indicate that drownings in the YKHC area have steadily declined since the program began. By 1992, just two years after the intervention began, 16 individuals have provided success stories describing how they were saved by their floatcoat. The program has been expanded to other villages in interior Alaska as well.

This program has been successful because it was tailored to the needs of the local people; it was culturally appropriate, and acceptable. They found that everyone needs an outdoor coat in the village, and residents would be much more likely to wear a float coat while boating than a standard PFD. The program is still ongoing, and is now a popular Christmas item in the villages each year (Ron Perkins, Third International Conference on Injury Prevention and Control, Melbourne, 1996).

OTHER EFFECTIVE INJURY PREVENTION STRATEGIES

Fire/Burn Injuries

Operable smoke detectors reduce the risk of dying in a house fire by 50%. The installation and maintenance of smoke detectors has been shown to be very effective in the prevention of fire/burn injuries in communities.

To facilitate community-based fire prevention programs, the IHS recently published *Designing and Implementing Fire Prevention Strategies in American Indian Communities: a Resource Manual* which describes how communities can develop their own local fire prevention programs.

Tap water scald injuries can be virtually eliminated by limiting water heater temperature to no more than 120 degrees Fahrenheit (48.9 degrees Celsius).

Motor Vehicle-Related Injuries

When properly used, child safety seats reduce the risk of fatal injury by 69% for infants and by about 50% for toddlers 1-4 years old. Using seat belts can reduce the risk of death in a crash by about 50%. Many Indian communities still have low rates of occupant restraint use compared to National or State rates.

Tribes should pass legislation to adopt or strengthen occupant restraint laws for adults and

children, and strictly enforce those laws. It is clear from the success of many states with primary enforcement laws, that strict laws and enforcement are needed to significantly increase occupant restraint use.

SOURCES OF INJURY DATA

The case studies above have demonstrated that the careful collection and analysis of local injury data where available is essential to developing effective strategies to reduce injuries in AI/AN communities. Without data, there is no basis for analyzing information, setting injury prevention goals or objectives, or developing a method to evaluate the effectiveness of those prevention measures that are taken. IHS Area or District Injury Prevention Specialists can advise and direct you to the database that has the information you need to gather data for your local injury problem.

Small communities may not have a large enough population base to generate large numbers of injuries. Fatal injury events may be very rare. Looking at several years of data may be necessary to generate the numbers needed for analysis. In these circumstances, look for injury hospitalization data, police reports, EMS reports, and other non-fatal sources of injury data to help create an injury profile in your community. Surrogates for injury data can also be used, such as conducting observational surveys of seat belt and child restraint use. Baseline occupant restraint survey data can then be used to help target interventions to increase usage and provide evaluation "benchmark" measures as well. Below is a brief description of where you can begin looking for injury data and resources.

To assist in the data collection process, IHS has developed Severe Injury Surveillance Forms for field use in conducting injury investigations. These forms can be adapted and modified for use in collecting injury data in your community. Injury data is also available through IHS medical records printouts. This data is derived from the medical records of AI/AN treated on an inpatient or outpatient basis at IHS medical facilities, contract care providers, or through tribally-operated health facilities. This data is available at the Service Unit and is accumulated by IHS to provide patient health information at Service Unit, Area, and national levels. By combining data from more than one source, it is possible to collect data of the following:

- Nature of injury (e.g., fracture, contusion, etc.)
- External cause of injury (e.g., motor vehicle-related, falls, etc.)
- Place of injury (e.g., home, highway, etc.)
- Influencing factors (e.g., alcohol)
- Age of injured by group (e.g., under 1 year, 1-4 years, etc.)
- Sex
- Number of hospital days (i.e., average length of stay)

Many IHS printouts are available that provide data on various aspects of the injury problem. Printouts provide a range of information regarding the health, demographics, geographic location, or other circumstances of the injured and the injury event. Each Area Injury Prevention Specialist maintains a current database of injury deaths and hospitalizations. With this data, specific injury profiles can be developed which provide information on major factors contributing to injury, deaths, and hospitalizations.

A wealth of local information on injuries and injury events is also generally available locally from the records of local police departments, ambulance services, first responder groups, school nurses, and other local sources. IHS also has data on all AI/AN deaths that it receives each year from the National Center for Health Statistics. Often utilizing all of these data sources are not necessary to determine what are the major injury problems and populations at risk in a community. Remaining focused on a specific injury problem and its risk factors and causes is the first step to initiating a program to prevent those injuries.

Injury Prevention Resources

- IHS Office of Program Statistics (301-443-1180) each year publishes the *Trends in Indian Health* and *Regional Differences in Indian Health* reference books. Both books provide good descriptions of injury statistics at the national level (Trends in Indian Health) and the regional IHS Area level (Regional Differences in Indian Health). The content of these books can now be found on the IHS internet website: www.ihs.gov and easily viewed or downloaded.

- IHS Injury Prevention program website: www.dehs.ihs.gov/noinjuries. This website has links to other injury-related data and sites, contacts for all the IHS Area Injury Specialists, and other good information on preventing injuries among Indian people.

- National Center for Injury Prevention and Control (NCIPC), CDC website: www.cdc.gov/ncipc/ncipchm.htm. This website contains injury statistics on AI/AN as well as the rest of the country which can be easily viewed and downloaded. NCIPC injury-related publications can be ordered on-line at no charge. Some of these publications specifically address injuries among AI/AN, such as *Homicide and Suicide Among Native Americans, 1979-1992*.

- Insurance Institute for Highway Safety website: www.hwysafety.org. Good information regarding motor vehicle-related injuries, risk factors, safety and prevention.

- National Highway Traffic Safety Administration (NHTSA) website: www.nhtsa.dot.gov. Large website with information on traffic safety, programs, and statistics by state and nationally.

- National SAFE KIDS Campaign website: www.safekids.org. Website of the national coalition devoted to reducing childhood injuries.

- American Academy of Pediatrics website: www.aap.org. Website of a national organization of pediatricians devoted to child health issues, including good information on preventing childhood injuries. In 1997, the Academy published *Injury Prevention and Control for Children and Youth*. An excellent resource book for injury prevention practitioners. AAP, P.O. Box 927, 141 Northwest Point Blvd, Elk Grove Village, IL 60009.

Injury Prevention Training

IHS teaches three courses in injury prevention training, all designed for community-based practitioners as well as IHS staff to learn the basics of preventing injuries in Indian communities. The three courses cover: 1) Introduction to injury prevention; 2) Intermediate Injury Prevention;

and 3) Advanced Injury Prevention. Each of these courses are approximately 1 week in length. Contact an IHS Area Injury Prevention Specialist for more information, or the IHS Injury Prevention website: www.dehs.ihs.gov/noinjuries.

OUTLINE FOR AN INJURY INTERVENTION PROGRAM

The following outline is designed to provide a simple, systematic tool for helping to develop an injury prevention program. The outline begins with the data collection process and follows the process through to the evaluation.

I. ASSESSING THE NEED

A. Data Gathering

Identify and gather existing injury data in your community. Potential sources of data are police reports, EMS run sheets, IHS reports, hospital Emergency Department log, etc.

B. Analyze Data

Who was injured?
What was the injury?
When did injury occur?
Where did injury occur?
Why did injury occur?
How did injury occur?

Identify problem area (e.g., motor vehicle crashes, bicycle-related injuries).

II. Problem Statement and Objectives

A. Problem Statement

This statement should be general and identify the target population and the problem to be addressed. (Example: The bicycle injury rate on the Reservation is twice as high as the State average.)

B. Outcome Objectives

Objectives should be specific, time-framed, measurable, and realistic given the injury problem and the time and financial constraints.

EXAMPLE: Bicycle helmet use will be increased from 10% to 20% among children 5-14 year olds on the Reservation within 12 months after starting the helmet program.

EXAMPLE: Within 12 months after starting the seat belt campaign and police enforcement strategies, seat belt use will increase from 45% to 55% on the Reservation.

C. Process Objectives

1. By May 1, 2004, 50 free helmet “prescriptions” will be distributed to all the physicians on the Reservation.
2. By May 1, 2004, all retail shops will have been contacted about the helmet discount

coupons.
3. By June 1, 2004, 200 discount coupons will have been distributed to all elementary and junior high school children on the reservation.

Evaluate if outcome and process objectives were met.

III. INTERVENTION PROGRAM

A. Mixed Strategy
The four basic types of interventions are:
Education/behavioral modification
Environmental modification
Enforcement/legislation
Engineering/technology

A combination of these types of intervention may produce the best result, but most programs will start by targeting one of the above interventions.

Example: The public needs to be informed and reminded to replace batteries and check smoke detectors, even though local tribal housing codes mandates the installation of detectors.

Example: A tribe can pass a mandatory seat belt law, but unless there is public support for the law and enforcement, then usage rates will remain low.

B. Prioritizing Interventions

The following considerations should be used in prioritizing the available intervention strategies:

1. How frequent is the injury?
2. What is the injury's severity?
3. What is the cost associated with this type of injury?
4. Do effective preventative measures exist?
5. Is there public support for this issue?

IV. Program Evaluation

Data gathered during evaluation enable researchers to create the best possible programs, to learn from mistakes, to make modifications as needed, to monitor progress toward the program's goal, and to judge the program's ultimate outcome. The steps involved in evaluating and modifying the program should include these nine criteria (from CDC. Evaluating Your Programs Worth: A Primer on Evaluation for Programs to Prevent Unintentional Injury, 1998):

1. Write a statement defining the objective(s) of the evaluation.
2. Define the target population.
3. Write down the type of information to be collected.
4. Choose suitable methods for collecting the information.
5. Design and test instruments appropriate to the chosen methods for collecting the information.
6. Collect raw information.
7. Process the raw information.
8. Analyze the processed information.
9. Write an evaluation report describing the evaluation's results.

Leading Causes of Injury Death by Age Group
Native Americans 0-24 years, 1993 - 1995

RANK	< 1	1-4	5-9	10-14	15-24
1	Suffocation 22	Fire/ Burn 44	Drowning 18	MV Occupant 32	MV Occupant 353
2	Homicide 18	Pedestrian 40	Pedestrian 12	Suicide 26	Suicide 261
3	MV Occupant 12	Drowning 29	Fire/ Burn 11	Homicide 21	Homicide 204
4	All Other Causes 5	Homicide 28	MV Occupant 9	Pedestrian 16	MV Other 155
5	Drowning 3	MV Occupant 25	Unintent. Firearm 7	Drowning 9	Pedestrian 93
6	Fire/ Burn 3	Suffocation 14	MV Other 7	MV Other 8	Drowning 44
7	Natural/ Environ 2	MV Other 9	Suffocation 6	Fire/ Burn 6	Unintent. Firearm 32
8	Fall 1	Fall 4	Homicide 5	Unintent. Firearm 6	All Other Causes 25

Source: National Center for Injury Prevention and Control, CDC:www.cdc.gov/ncipc/ncipc.htm. Includes all American Indians and Alaska Natives in the United States. Number of deaths during the 3-year period for each cause is shown in the appropriate box.

Leading Causes of Injury Death by Age Group
Native Americans 0-24 years, 1993 - 1995

RANK	25-34	35-44	45-54	55-64	≥ 65
1	MV Occupant 273	MV Occupant 175	MV Occupant 83	MV Occupant 49	Fall 68
2	Suicide 264	Homicide 151	Suicide 67	Pedestrian 44	MV Occupant 56
3	Homicide 235	Suicide 151	Pedestrian 62	Natural/ Environ 33	Unspecified 45
4	MV Other 137	Poisoning 107	Homicide 9	Homicide 31	Fire/ Burn 37
5	Pedestrian 122	Pedestrian 97	MV Other 44	Fall 29	Natural/ Environ 36
6	Poisoning 82	MV Other 75	Poisoning 35	Suicide 27	Suffocation 26
7	Drowning 73	Drowning 52	Fall 26	MV Other 24	Adverse Effects 25
8	Fall 35	Fall 34	Natural/ Environ 26	Poisoning 6	Pedestrian 24

Source: National Center for Injury Prevention and Control, CDC: www.cdc.gov/ncipc/ncipc.htm. Includes all American Indians and Alaska Natives in the United States. Number of deaths during the 3-year period for each cause is shown in the appropriate box.

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